MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF PRIMARY CARE AND RURAL HEALTH
P.O. BOX 570, JEFFERSON CITY, MO 65102-0570

APPLICATION FOR THE MISSOURI HEALTH PROFESSIONAL LOAN REPAYMENT PROGRAM

ALL INFORMATION IS CONFIDENTIAL AND FOR PROGRAMMATIC PURPOSES ONLY

MUST BE TYPED OR PRINTED

SECTION 1 – APPLICANT'S PERSONAL INFORMATION

APPLICANTS LAST NAME	FIRST NAME	MI.	APPLICANTS SOCIAL SECURITY NUMBER

OTHER NAMES USED LAST NAME	FIRST NAME	MI.

DATE OF BIRTH	EMAIL ADDRESS	HOME TELEPHONE NUMBER	CELL PHONE NUMBER

☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED

AGES OF DEPENDENTS

PRESENT ADDRESS STREET CITY STATE ZIP

LANGUAGES SPOKEN FLUENTLY OTHER THAN ENGLISH	COUNTY	US CITIZEN ☐ YES ☐ NO

LAST NAME OF SPOUSE	FIRST NAME	MI.	SPOUSE SOCIAL SECURITY NUMBER

FAMILY INCOME FROM PREVIOUS YEAR'S INCOME TAX RETURN

NAME OF RELATIVE NOT LIVING WITH YOU	RELATIONSHIP TO YOU

RELATIVE STREET ADDRESS CITY STATE ZIP	RELATIVE HOME TELEPHONE NUMBER

ADDITIONAL INFORMATION FOR REPORTING PURPOSES (OPTIONAL)

ETHNICITY

☐ WHITE ☐ JAPENESE ☐ HAWAIIAN ☐ OTHER PACIFIC ISLANDER
☐ AFRICAN-AMERICAN ☐ ASIAN INDIAN ☐ SAMOAN ☐ OTHER
☐ AMERICAN INDIAN ☐ KOREAN ☐ FILIPINO
☐ CHINESE ☐ VIETNAMESE ☐ GUAMAN

SECTION 2 – APPLICANTS EMPLOYMENT INFORMATION

PRESENT EMPLOYER	STREET ADDRESS CITY STATE ZIP

DATE EMPLOYED	YOUR TITLE	SUPERVISORS NAME

WORK TELEPHONE AND EXTENSION	THIS FACILITY IS	COUNTY
( )	☐ PUBLIC ☐ NON-PROFIT ☐ FOR PROFIT	

_____ HOURS WORKED PER WEEK _____ % DIRECT PATIENT CARE _____% MEDICAID PATIENTS SEEN BY FACILITY

SECTION 3 – APPLICANTS NURSING/RESIDENCY PROGRAM INFORMATION

NAME OF LAST SCHOOL/RESIDENCY PROGRAM ATTENDED	TELEPHONE NUMBER ( )

SCHOOL ADDRESS STREET CITY STATE ZIP

LIST TYPE AND DATE YOU COMPLETED REQUIREMENTS FOR YOUR DEGREE, DIPLOMA OR RESIDENCY

☐ ASSOCIATE NURSING DEGREE
☐ DIPLOMA NURSING DEGREE
☐ BACHELOR NURSING DEGREE
☐ ADVANCED NURSE PRACTITIONER
☐ DOCTOR OF ALLOPATHIC MEDICINE
☐ DOCTOR OF OSTEOPATHIC MEDICINE
☐ DEGREE IN DENTAL SCIENCES
☐ RESIDENCY _____ (TYPE)
☐ DOCTORATE OF PSYCHIATRY
☐ DOCTORATE OF PSYCHOLOGY
☐ MASTERS LEADING TO LCSW
☐ MASTERS LEADING TO LPC
☐ DOCTORATE NURSE (Ph.D., DN.P or Ed.D.)

DATE COMPLETED (MM/DD/YYYY)

ARE YOU CURRENTLY HOLDING PERMANENT MISSOURI LICENSE OR CERTIFICATION? ☐ YES ☐ NO	IF YOU ARE A PHYSICIAN ARE YOU BOARD CERTIFIED? ☐ YES ☐ NO
MISSOURI LICENSE NUMBER	MISSOURI BOARD CERTIFICATION NUMBER

LIST ANY OTHER STATES WHERE YOU ARE LICENSED TO PRACTICE AND YOUR LICENSE NUMBER

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SECTION 3 – APPLICANTS NURSING/RESIDENCY PROGRAM INFORMATION (CONTINUED)

DO YOU HAVE AN EXISTING SERVICE OBLIGATION? ☐ YES ☐ NO	ARE YOU IN DEFAULT OF THIS OBLIGATION? ☐ YES ☐ NO	
IF YES, NAME OF PROGRAM	TELEPHONE NUMBER ( )	DATE OBLIGATION COMPLETE

HAVE YOU EVER DEFAULTED ON A STATE OR FEDERAL LOAN?
☐ YES ☐ NO

IF YES, LIST NAME OF LOAN, TYPE OF LOAN AND REASON FOR DEFAULT.

LENDING INSTITUTION OR CURRENT HOLDER OF LOAN	ACCOUNT NUMBER	BALANCE	CONTACT PERSON	ADDRESS OF CONTACT PERSON STREET, CITY, STATE, ZIP	TELEPHONE NUMBER
TOTAL: (Attach additional sheets if necessary)					

APPLICATIONS WITHOUT APPROPRIATE ATTACHMENTS WILL NOT BE PROCESSED. THE FOLLOWING INFORMATION MUST BE ATTACHED.

HAVE YOU ENCLOSED?

ALL APPLICANTS

☐ LETTER OF SUPPORT FROM YOUR EMPLOYER

☐ COPY OF YOUR PROMISSORY NOTE(S)

☐ COPY OF YOUR CURRENT LICENSE

PHYSICIANS, DENTISTS, PSYCHIATRISTS, PSYCHOLOGISTS

☐ COPY OF SITE CONTRACT

☐ COPY OF SLIDING FEE SCALE

☐ PAYER MIX (MEDICAID, MEDICARE, PRIVATE PAY, ETC.)

REGISTERED NURSES, LCSW, LPC

☐ COPY OF YOUR OFFICIAL JOB DESCRIPTION

☐ DESCRIPTION OF SERVICES PROVIDED BY EMPLOYER

ADVANCE AND DOCTORATE PRACTICE NURSES

☐ COPY OF YOUR DOCUMENT OF RECOGNITION

☐ COPY OF YOUR OFFICIAL JOB DESCRIPTION

☐ DESCRIPTION OF SERVICES PROVIDED BY EMPLOYER

The undersigned hereby authorized the full disclosure of any information regarding the nature, amount, terms and status of this loan for the purpose of entering an agreement with the Missouri Department of Health and Senior Services for repayment of said loans.

The undersigned hereby certifies the accuracy of the information in the application and applies to enter into an agreement with the Missouri Department of Health and Senior Services for repayment of a portion of the educational loans listed above.

PLEASE PRINT FULL NAME

SIGNATURE	DATE